



Behavioral Health Finance and Integration Options Stakeholder Meeting

Senate Miller Office Building
6 Bladen Street
Annapolis, MD 21401
East I and II
1:30-3:30pm

Workgroups

- Four workgroups have been created to provide insight into critical areas:
 - Systems Linkage: To make a recommendation on those factors that should be present to promote "integration." For example, should there be a shared electronic health record among all providers within an MCO? What factors indicate "integrated" care, and what factors indicate "collaborative" care?
 - Evaluation and Data: To determine what data is available and relevant to the ultimate recommendation on the model, and to make a recommendation on potential measures to evaluate any selected model.

Workgroups

- State and Local Roles: To make a recommendation on what services/financing should be left outside a “Medicaid” integrated care model to accommodate non-Medicaid eligible populations, or non-Medicaid-eligible services. This Workgroup will also make a recommendation on the roles that state and local government should perform depending on which services/financing are left outside of the Medicaid financing model, as well as how to support and interface with selected model.
- Chronic Health Homes: To make a recommendation on a new “Health Home” service under the Affordable Care Act, and make a recommendation on how the new service could be developed to support any integration model. For example, this workgroup would help define the service; define the population eligible for the service; and define the provider qualifications to deliver the service.

Criteria to Select a Model

1. Best ensures delivery of the right service, in the right place, at the right time, by the right practitioner
2. Best ensures positive health outcomes in behavioral health and somatic care using measures that are timely and transparent
3. Best ensures preventive care, including early identification and intervention
4. Best ensures care across an individual’s lifespan
5. Best ensures positive consumer engagement
6. Best aligns with treatment for chronic conditions

Criteria to Select a Model

- 7. Best ensures the delivery of culturally and linguistically competent services that are evidence-based and informed by practice-based evidence
- 8. Best ensures that the system is adaptable over time, as other payment and delivery system reforms occur, without loss in value or outcomes
- 9. Best ensures program integrity and cost-effectiveness
- 10. Best ensures administrative efficiencies at state, local, plan, provider, and consumer/family levels
- 11. Best ensures seamless transitions as service needs change, and as program eligibility changes

Potential Models

Model 1: Protected Carve-In

Medicaid-financed behavioral health benefits would be managed by Medicaid managed care organizations (MCOs) through a “protected carve-in”. The MCOs would be responsible for managing a comprehensive benefit package of general medical and behavioral services. Contractual conditions would require the MCOs to employ specific behavioral health practitioners in clinical leadership positions, would specify the credentials of staff who performed behavioral health utilization management, and would put the MCOs at risk for demonstrating that they were assuring access to the behavioral health benefit. This model would protect funds spent on behavioral health treatment but would allow the MCOs to have flexibility in how they structured care coordination, utilization management, etc.

Potential Models

Model 2: Risk-Based Carve-Out

Medicaid-financed specialty behavioral health benefits and the State/block grant-funded benefit package would be managed through a risk-based contract with one or more Behavioral Health Organizations (BHO). Contractual conditions would be aligned with those of the Medicaid MCOs; performance standards would be robust and performance risk would be shared with MCOs for continued implementation of health homes for persons with behavioral health conditions, as well as health homes for persons with chronic medical conditions and for improvement in health outcomes for persons enrolled in health homes. The services delivered through the BHO would be specialty behavioral health services. MCOs would continue to provide specified behavioral health care typically associated with primary care providers.

Potential Models

Model 3: Risk-Based Population Carve-Out

As in Model 1, all Medicaid-financed behavioral health benefits and general medical benefits would be delivered under a comprehensive risk-based arrangement. In this model, however, Medicaid would competitively select one or more specialty health plan(s) to manage the comprehensive benefit package for individuals with serious behavioral health diagnoses. If such a diagnosis is present, the person would be enrolled in a specialty health plan, which would be required to deliver the full array of behavioral health and medical benefits. If such a diagnosis is not present, the person would be enrolled in a traditional MCO to receive his/her full array of behavioral health and general medical benefits.

Workgroup Process

- 4-5 meetings of each Workgroup
- Workgroup reports due early September to inform the Final Report due September 30
- Information regarding agenda, materials, and meeting reminders for each Workgroup will be sent to entire group every Friday
- To get on this e-mail list, write to bhintegration@dhmh.state.md.us

Meetings Schedule

Large BH Integration Group:

-June 5 1:30-3:30pm
 -July 9 1:30-3:30pm
 -August 14 1:30-3:30pm
 -September 11 1:30-3:30pm

Systems Linkage Workgroup*:

-May 10 1:30-3:30pm
 -May 31 1:30-3:30pm
 -June 28 1:30-3:30pm
 -July 26 1:30-3:30pm
 -August 23 1:30-3:30pm

Evaluation (Data) Workgroup*:

-May 9 10:00-11:30am
 -June 6 2:00-3:30pm
 -July TBD
 -August 8 10:00-11:30am

State/Local and Non-Medicaid Workgroup*:

-May 8 2:30-4:40pm
 -June 13 1:30-3:30pm
 -July 11 1:00-3:00pm
 -August 21 1:00-3:00pm

Chronic Health Homes Workgroup*:

-May 17 12-1:30pm
 -June 14 1:30-3:30pm
 -July 12 1:30-3:30pm
 -August 9 1:30-3:30pm

*Workgroup meeting dates and times are subject to change.

Submitting Comments

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhhm.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter:

Organization:

Date: [Click here to enter a date.](#)

Contact Information:


Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment:

E-mail all comments and suggestions to bhintegration@dhhm.state.md.us.

Please specify the **Related Workgroup(s)** in the subject of your e-mail, if applicable.



Overview of Current Behavioral Health Financing Systems:

The Mental Hygiene Administration

Melissa Schober, MHA

PMHS Service System

- ▶ MHA operates and oversees the Public Mental Health System (PMHS):
 - Five state hospitals (mostly forensic population)
 - Two Regional Institutes for Children and Adolescents
 - Community Mental Health Providers
 - Outpatient Programs
 - Ongoing rehabilitative services (PRP, RRP)
 - Crisis Services
 - 1915(c) Waiver Services: Traumatic Brain Injury and Residential Treatment Facility (children and adolescents)

13

Who Uses the PMHS?

- In SFY2010, 122,067 consumers used the PMHS – 29% increase from SFY1997.
 - About 10% are uninsured (12,973)
 - 46% were under 21 and under; 56% 22+
 - 48% male and 52% female
 - 48% African American; 44% Caucasian; 8% Other.
- Average annual cost per consumer in SFY2011 was \$4,711

Source: MHA FY2010 Annual Report, PMHS
Quarterly Data through Dec. 2011

14

Financing (Carve-Out)

- In July 1997 Maryland was granted an 1115 Waiver.
 - The HealthChoice Waiver requires majority of Medicaid-eligible consumers to enroll in and receive their somatic care, substance abuse treatment, and referral for mental health services through a managed care organization (MCO).
- “Specialty” mental health services are delivered through a “carve-out” arrangement. Providers are paid on a fee for service basis.

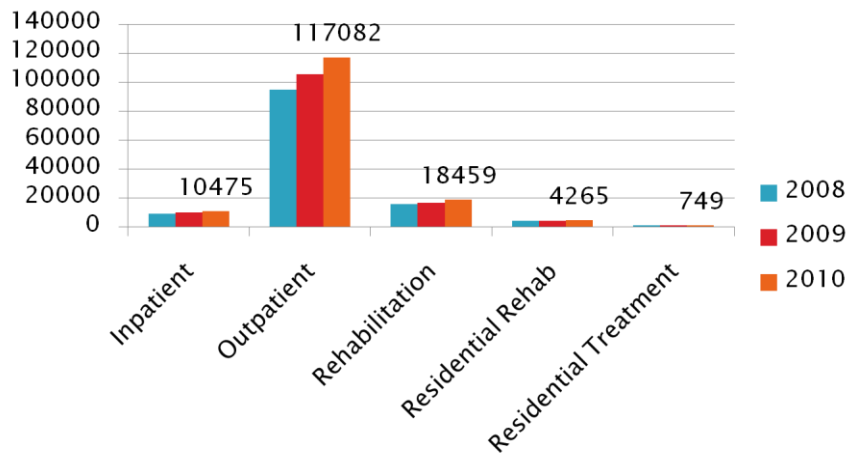
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Managing the Carve Out

- MHA is assisted by an Administrative Services Organization (ASO), which operates under a contract with MHA.
- The ASO, ValueOptions, authorizes services and provides utilization management, claims processing, evaluation services, and collects data.

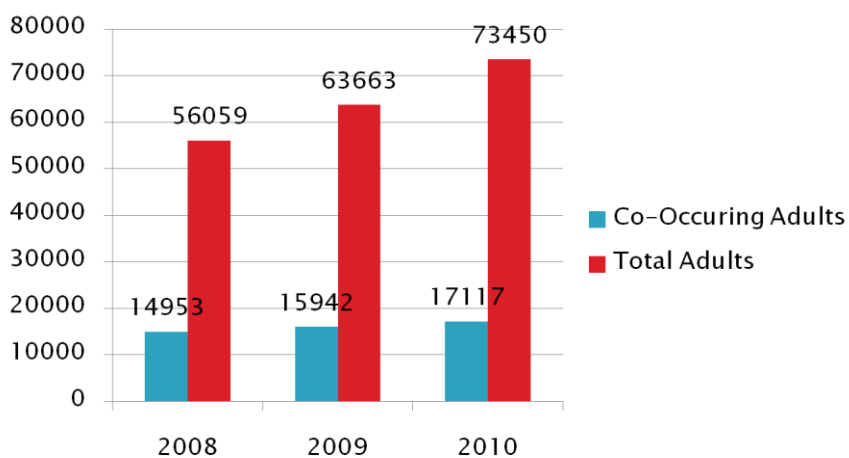
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Services Provided by PMHS



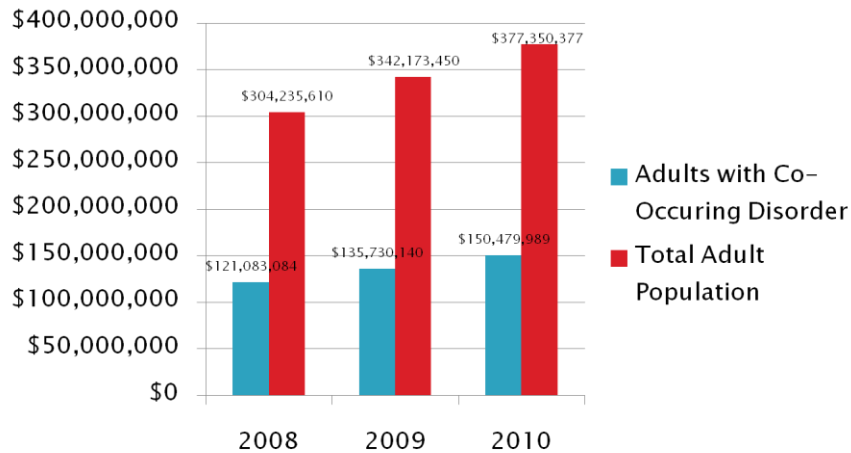
Source: MHA FY2010 Annual Report 17

Adult Consumers with Co-Occurring Disorders



Source: MHA FY2010 Annual Report 18

PMHS Expenditures for Adults with Co-Occurring Disorders



Source: MHA FY2010 Annual Report

19

Overview of Current Behavioral Health Financing Systems:

The Alcohol and Drug Abuse Administration

Kathleen Rebbert-Franklin, ADAA

20

ADAA Mission

The Alcohol and Drug Abuse Administration is committed to providing access to a quality and effective substance use disorder prevention, treatment, and recovery service system for the citizens of Maryland.

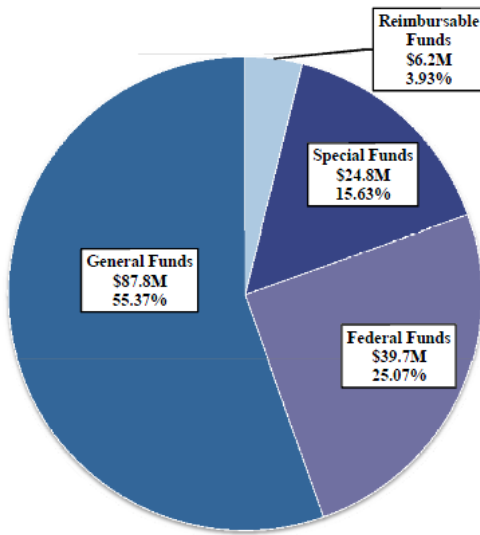
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ADAA Purpose

- Single State Agency (SSA) responsible for planning, coordination, and regulation of the statewide network of substance abuse prevention, treatment, and recovery services
- Provides fiscal management and technical assistance to 24 jurisdictions who either purchase and/or provide services
- Serves as a resource for information about substances of abuse as well as prevention, treatment, and recovery services available in the community

22

ADAA Fiscal 2013 Allowance

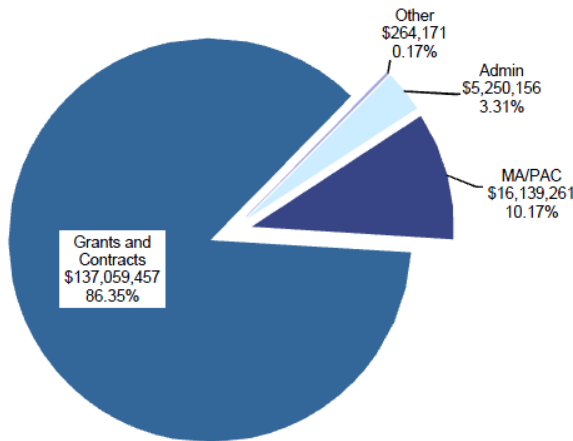


The fiscal 2013 allowance for the ADAA is \$158.7 million (+0.95%).

Funding Streams

- Federal Grants
 - Substance Abuse Prevention and Treatment Block Grant
 - Maryland's Strategic Prevention Framework (MSPF)
 - Access to Recovery (ATR)
 - Tobacco Enforcement
- General State Funds
- Special Funds (Gambling)
- Reimbursable Funds (Drug Court, Prescription Drug Monitoring Program)

ADAA Fiscal 2013 Expenditure Categories



Grants and contracts comprise the majority of ADAA's spending, with these expenditures supporting substance abuse prevention, treatment, and recovery services.

25

Methods of Funding Services

- Funding for prevention, treatment, and recovery services through "grant awards" to all 24 jurisdictions (23 Counties and Baltimore City). This accounts for approximately 82% of funds distributed.
- Contracts to private and non-profit providers for population-specific services account for approximately 18% of funds distributed.

26

Methods of Funding Services: Local Jurisdictions' Service Delivery System

- Based on Needs Assessment Data
- Prevention and Treatment Coordinators responsible for Conditions of Award (Monitoring, Outcomes)
- Contract Awards (fee-for-service or cost-reimbursement contracts with private vendors)
- Direct provision of care (generally through Health Department or State employees)

27

Methods of Funding Services: Statewide Contract Services

- Level III.3 (Clinically-Managed-Medium Intensity) Women and Children's Programs
- Court-Ordered Individuals Level III.3 (Clinically-Managed-Medium Intensity) and III.5 (Clinically-Managed-High Intensity) Treatment

28

Methods of Funding Services: Medicaid Expansion

- Transfer of \$16.1 million in General Funds to Medicaid/Primary Adult Care (PAC) Program to fund substance abuse treatment (increase of \$6.77 million from FY 2012)
- MA/PAC reimburses for ambulatory services. Residential and recovery services are purchased through jurisdictions' grant awards.

29



Overview of Medicaid Managed Care Program

Susan Tucker, DHMH

30

Maryland Medicaid Enrollment

- In FY 2011, there was an average of 870,000 enrollees with full benefits (18% increase)
 - 82% in Managed Care Organizations (MCOs)
 - 18% fee-for-service (FFS) - mostly dual eligibles, individuals in spend-down categories, in nursing home or long term care
- Currently, there are more than 922,000 people enrolled
 - Roughly 1 in 6.5 Marylanders - includes: full benefits, partial benefits, Medicare cost sharing
- Cost is projected to be \$6.2 billion Total Funds (federal and state funds) for FY 2011 (not including DDA and MHA)
- In FY10, Maryland Medicaid consumed about 25% of State budget (compared to 22% nationwide*)

*National Governors Association

31

HealthChoice Managed Care Program

- In 1997, Managed Care Organizations (MCOs) became responsible for providing the majority of Medicaid services
- Currently, 7 MCOs serve over 715,000 enrollees, the majority of whom are children (about 476,000 or 67%)
- The FFS and HealthChoice benefit package is the same with the exception of small add-ons by MCOs
- MCOs receive a monthly capitation payment for each enrollee
 - Benefit package includes substance abuse services and mental health services provided by PCPs

32

HealthChoice Carve-Outs

- **33%** of services are carved-out of HealthChoice and available on a fee-for-service (FFS) basis, mostly for specialty mental health, long-term care and health-related special education services.
- Carve-outs include:
 - **Public Mental Health System**
 - (NOTE: MCO do pay for MH services provided by PCPs)
 - **ICF-MR**
 - Health-related special education services (IFSP and IEP)
 - Nursing home and any long-term facility more than 30 days
 - Personal Care and Medical Day Care
 - Transportation
 - Home- and Community-based Waiver Services
 - Dental care for children and pregnant women (DentaQuest)

33

Self-Referred Services

- Enrollees in managed care can self refer for the following services:
 - **Substance Abuse Services**
 - Services provided by school-based health centers
 - Family planning services
 - Initial medical examination for a child in state supervised care
 - One annual diagnostic evaluation service visit for enrollee diagnosed with HIV/AIDS
 - Renal Dialysis Services
 - OB/GYN care provided to a pregnant women already receiving prenatal care
 - Emergency Services
 - Immediately needed services for an unforeseen illness at an out of network FQHC

34

How is Medicaid Managed Care Different from Other Managed Care?

- More Enrollee Protections
 - Ombudsman and Administrative Care Coordination units in each local health department
 - Complaint and Appeal systems
 - Enrollee Hotlines
 - Fair Hearing Process
 - Continuation of Benefits during appeals

35

HealthChoice Quality Assurance Activities

- Systems Performance Review
- Satisfaction Surveys/CAHPS
- HEDIS Measures
- Value-Based Purchasing
- Consumer Report Card
- Performance Improvement Projects
- EPSDT Medical Record Reviews

36

HealthChoice Evaluation

- 1115 Waiver requirements include performing periodic evaluations of the program. The results of the most recent evaluation show:
 - HealthChoice is a mature, stable program
 - Provides a medical home to enrollees and promotes prevention and chronic care management
 - Outcomes for key populations tend to exceed national Medicaid performance and, in some cases, commercial market performance
 - Reduces program cost growth by creating a methodology for predictable, flexible reimbursement

37

Primary Adult Care (PAC)

- PAC Program, which began in July 2006, is a limited benefit package for childless adults under 116% of FPL
- Covered services include:
 - Primary Care
 - Limited lab and diagnostic services
 - Community-based mental health services (carved out of MCO capitated payment)
 - Community-based Substance Abuse services (carved-into MCO capitated payment)
 - Pharmacy
 - Facility fees for emergency room visits
- As of May 2011, there were approximately 45,000 enrollees in PAC (or 5% of the total Medicaid population).

38

Recent Enhancements to Substance Abuse Program

- Effective January 1, 2010 community substance abuse services were increased
 - HealthChoice and fee-for-service rates were increased (all MCOs and FFF system pay the same rates)
 - Community-based substance abuse services were added to PAC
 - HealthChoice and PAC recipients can self-refer for substance abuse services (OHCQ certified addictions providers don't have to be separately credentialed by MCOs to provide self-referred substance abuse services)

39

PAC Covered Substance Abuse Services

- Buprenorphine and naloxone
- Community-based SA services were added in January 2010 including:
 - Comprehensive substance abuse assessment
 - Individual, family, or group counseling
 - Methadone maintenance
 - Intensive outpatient treatment
- Services delivered in hospitals and HSCRC controlled clinics are not covered under PAC
 - These services are covered under HealthChoice

40

Codes and Rates for Self-Referred Community-Based Substance Abuse Services

| Service | Code | HCPC Description | Unit of Service | New Rate |
|-------------------------------------------------|-------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------|
| Comprehensive Substance Abuse Assessment (CSAA) | H0001 | Alcohol and/or drug assessment | Per assessment | \$142 |
| Individual Outpatient Therapy | H0004 | Behavioral health counseling and therapy | Per 15 minutes | \$20 |
| Group Outpatient Therapy | H0005 | Alcohol and/or drug services; group counseling by a clinician | Per 60-90 minute session | \$39 |
| Intensive Outpatient | H0015 | Alcohol and/or drug services; intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education. | Per diem (minimum two hours of service per session) Maximum four days per week | \$125 |
| Methadone Maintenance | H0020 | Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program) | Per week | \$80 |

41

Current Challenges with Behavioral Health Services

- Hospital payments
 - ValueOptions and MCOs deny payments because unclear which entity is responsible for hospitalization
 - Unclear diagnosis upon admission
 - Co-occurring mental health and somatic hospitalization
 - Will continue as long as one entity is not responsible for all health care services
- Care coordination
- Data exchange

42



Behavioral Health Reorganization

Patrick Dooley, DHMH

43

Behavioral Health Administration

- Build on the strengths of the current system
- Collaborate closely with the Medicaid financing initiative
- Solicit input from both internal and external stakeholders

Behavioral Health Administration

- Process
 - Solicit public comment regarding the composition of a Behavioral Health Administration – May 2012
 - Draft organizational chart for public comment – July 2012
 - Report submitted to the legislature – September 2012

Questions for Public Comment

- What are the key functions of a Behavioral Health Administration?
- How should a Behavioral Health Administration be organized to accomplish these key functions?
- What are the recommended transition steps to create a merged Behavioral Health Administration?



Behavioral Health Finance and Integration Options Stakeholder Meeting

Please submit any remaining questions or comments to
bhintegration@dhmh.state.md.us.

For more information on integration efforts and future meetings, visit
<http://www.dhmh.state.md.us/bhd/SitePages/integrationefforts.aspx>.